CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
MEETING MINUTES

October 18 and 19, 2012
Doubletree Hotel
2001 Point West Way
Sacramento, CA 95815
(916) 929-8855

CMHPC Members Present:

John Black, Chair
John Ryan, Chair-Elect
Cielo Avalos
Patricia Marrone Bennett, Ph.D.
Josephine Black
Doreen Cease
Cindy Claflin
Michael Cunningham
Linda Dickerson
Amy Eargle (for Kathleen O'Meara)
Steven Grolnic-McClurg
Karen Hart
Glenn Hutsell
Dale Mueller
Adam Nelson, M.D. (Thursday only)
Gail Nickerson
Jeff Riel
Daphne Shaw
Walter Shwe
Stephanie Thal
Jaye Vanderhurst
Monica Wilson
Susan Wilson

Staff Present:

Jane Adcock, Executive Officer
Mike Gardner
Brian Keefer (Thursday only)
Andi Murphy
Narkesia Swanigan
Tracy Thompson

Thursday, October 18, 2012

1. Welcome and Introductions

Chair John Black brought the meeting to order. Planning Council members, staff, and visitors introduced themselves.

2. Opening Remarks

Supervisor Phil Serna greeted the Planning Council members. He recognized the importance of having the Planning Council to hear from elected representatives in terms of their partnerships with providers, consumers, and family members.

Supervisor Serna stated that he also serves on the Sacramento County Mental Health Board. Lately he has been grappling with homelessness – a subject that does not have a sole contributing circumstance; it is complex and complicated. Contributors include not just economic condition, but also substance abuse, alcohol abuse, and mental health issues.

It is frustrating and challenging to get the homeless the services they need, when many of them are reluctant to have any connection to formalized health: clinical counseling, psychotropic medication, etc. Supervisor Serna informed the Planning Council that he will continue to educate himself on how to best guide local policy, as well as to seek input from professionals such as the Planning Council.

Supervisor Serna informed the council that Sacramento has initiated an anti-stigma campaign with the help of Senate President Pro Tem Darrell Steinberg' office. It is progressing very well.

Supervisor Serna welcomed the Planning Council to Sacramento.

3. Joe Mortz Remembrance and Memorial Award Overview

Chair Black stated that through the Adult System of Care Committee, and through Joe Mortz's hard work and creativity in this and other organizations, the Planning Council was looking at instituting an award: "Spotlight on Excellence."

John Ryan opened the floor for Planning Council members to have an opportunity to talk about their experience with Joe, and to recognize his contributions to the Planning Council over the years.

- Mr. Ryan had appreciated his passion for mental health, his sense of humor, and certainly his advocacy.
- Karen Hart remembered Joe's passion for advocacy of what he believed. He never held back his opinion, strived to get his point across, and his work done. He also cared deeply about the underdog.
- Walter Shwe joined the Planning Council at the same time as Joe. Joe was a person who pushed Mr. Shwe, especially during his tenure as president, to see if the Planning Council could do more to affect policy. Mr. Shwe will miss Joe as a colleague and fellow consumer.
- Dale Mueller noted that she and Joe had talked about hope and resiliency, as well as recovery and living a full life. She could not say enough about Joe's own hope and resiliency even in his last days. It is the epitome of hope to be able to see the bright side in the midst of debilitating illness.
- Monica Wilson spoke about Joe as her friend. He had encouraged her as a new Planning Council member when she became the Chair of the Children and Youth Subcommittee, telling her that the place to begin is when you are new and your heart is fresh. Joe was always very honest and transparent, and passionate about everything he believed in and that the Planning Council advocates for.
- Chair Black shared a remembrance of traveling to Redding to help Joe establish an art association.
- All the speakers expressed that they will miss Joe tremendously.

Andi Murphy stated that the Certificate of Excellence had been Joe's idea: rewarding people in their communities for having small organizations, preferably peer-run, that

provide services. The award is an educational tool for the counties – they can ask themselves if they have any programs like this.

Ms. Murphy stated that the frequency of the award is to be determined – possibly every two to three years. She shared a sketch of how it might work.

Mr. Ryan suggested that if the Planning Council receives a large number of nominations, perhaps the award could be given on a monthly basis. It is a good way to raise the visibility of mental health programs in counties.

Ms. Murphy stated that the areas that the Adult Systems of Care Committee had thought they would highlight for this year could be programs that best integrate primary health care and mental health care; another theme could be employment.

Stephanie Thal commented that if the Planning Council members go out to the county organizations they are aware of and encourage them to apply, there should be no problem getting applications.

Mr. Shwe felt that the project should be placed within a committee, since the Adult Systems of Care Committee no longer exists. It is not effective time-wise for the full Planning Council to plan the project.

Ms. Thal and Patricia Marrone-Bennett preferred not to limit the award by category. Dr. Bennett posed the question of whether the Planning Council should establish criteria about the specific populations of people to be served – serious and chronic mental health, Prevention and Early Intervention (PEI), and so on?

Steven Grolnic-McClurg felt that the award development should not be placed within a committee. It is about the spirit of rewarding excellence and consumer-driven, consumer-focused programs. He suggested having a small committee work through the award's development.

Mr. Ryan encouraged a broad category for the qualified programs: anything that accomplishes the goal of people having a life in the community.

Josephine Black suggested that it might be worthwhile to have a pilot year – to publicize the award without any restrictions and see what it nets and what kinds of responses it gets.

Daphne Shaw was extremely pleased that all the initial hard work done in the Adult Systems of Care Committee was going to be used as a memorial for Joe.

Jeff Riel requested having a cover letter included when information about the award is sent to partner agencies.

> ***Motion****: To approve the Joe Mortz Memorial Award, and to refer it to the Communications workgroup to work out the details, was moved by John Ryan, seconded by Gail Nickerson. Motion passed unanimously.*

4. Discussion of Issues in the Restructuring of Planning Council Committees and Meetings

Facilitator Brian Keefer stated that the two essential goals of this discussion were to review the ideas and issues brought forward at the June meeting, and to revisit the format of the April and June meeting. Mr. Keefer referred the Planning Council to a table developed by the Task Force that listed the issues and recommendations.

The Task Force had also edited the *Operating Policies and Procedures* manual using the "Track Changes" mode, to show line by line what was changed.

Narkesia Swanigan presented the review of the issues and concerns and corresponding Task Force recommendations. She noted that the issues on the table were taken straight from the June Minutes.

1. What is the problem we are trying to resolve?

- There are insufficient staff resources and capacity distributed amongst the many committees.
- With Realignment, we need to streamline to be more effective.
- Staff must be able to focus on certain issues.

Recommendation: The restructure is an observable change: it enables us to address the concerns and maximize current resources, as well as create an opportunity for staff to focus on a single topic.

2. There is a loss of understanding in what's happening within the committees and any level of detail on issues they are addressing.

Many Planning Council members felt a loss of communication among the committees because everyone was consumed with what they were doing.

Recommendation: Have the Planning Council become more action-oriented, and have conference calls in between quarterly meetings.

3. Can we bring outside experts in to participate in the Ad Hoc Committees? Can we pay for their travel?

Recommendation: Have experts call in to meetings via teleconference if travel becomes an issue.

4. How is the Planning Council planning to interface with other state departments so that our work influences policy and programming?

Recommendation: If we are going to have department representatives come to meetings, we need to use their time effectively.

5. We have concerns around federal, state, and regional healthcare issues.

There was agreement that mental health and substance abuse are becoming enveloped into behavioral health as a singular delivery system.

6. How will we determine which are the important issues? How will we maintain a balanced focus on children and youth, and age-related issues?

A caucus could be developed to run with any issues that may come up.

We need to make sure to focus on the lifespan: from children and youth to geriatrics.

Discussion

Ms. Hart: Bev Abbott's idea of a caucus could help solve the missing piece of the neglected age groups; the caucus does not require staffing.

Ms. Shaw: A concern about the caucus concept: if action needs to happen following a discussion, wouldn't staff be needed?

Ms. Hart: A caucus would not be action-oriented, but would carry the philosophy of calling attention to age-related concerns. We have all seen that many kinds of organizations and groups can become adult-focused very quickly.

Dr. Bennett: If people came together and found an issue that requires action, we should assume that the item would go to one of the three standing committees, the Executive Committee, or leadership, and then be brought forward to the full Planning Council with staff support.

Mr. Grolnic-McClurg: We need to realize that if we decide to narrow our focus, and choose issues upon which to assign committees, staff, and expertise, we won't be as broad as we were before. Another possibility is to have ad hoc groups for specific issues that need timely attention.

Mr. Keefer: The Issue Request mechanism could be adapted to address particular issues.

Chair Black: Adrienne Cedro-Hament would want to ensure that the Planning Council does not forget the category of cultural diversity.

Cielo Avalos: We could have Guiding Principles for the Committees to ensure that we keep every category in mind.

Mr. Keefer directed the Planning Council to the next concerns in the table.

7. The Planning Council needs to be more responsive and flexible. How will the Planning Council be able to follow through on projects with long-term effects within the new structure?

The discussion had recognized that this has always been a constant goal. Also, perhaps staff will be able to focus on more content-specific projects. The Executive Officer could develop guidelines for outcomes and deliverables.

8. How has the staffing for the Planning Council changed?

Essentially, two staff positions were reclassified to provide the Planning Council with an opportunity to create more in-house expertise in dealing with issues with local mental health boards, data, and other subjects that could come within its purview.

9. What about work of existing committees – does it fade into the background, or continue in new committees?

The restructure doesn't erase what happened in the past. It makes concrete the issues to focus on in the future.

Dr. Bennett: a chronology of past accomplishments would be helpful.

Mr. Keefer: The webpage could contain that information. A more active way would be for people to send out summaries of accomplishments at the end of each year.

Executive Director Adcock: In the packets is a matrix that depicts Planning Council mandates, and we have started to fill it in with recent projects and activities. We have been asking the Committees to add to it. It will be posted on the web and updated on a continuing basis.

Susan Wilson: It's very important that records of our accomplishments get sent to the local mental health planning boards. We need to think about informing our constituents.

10. What are the advantages of current committees? And, how are we going to translate that historical perspective?

Ms. Nickerson: The Advocacy Committee is certainly focusing on action. We want to bring our history with us; people are concerned that the interests they have been supporting over time do not disappear.

Ms. S. Wilson: We need to have ways for the committees work together on different projects. Useful data they might have needs to be shared. Even though we have fewer committees, we need to focus on going deeper into issues.

Ms. Mueller: We need to be mindful about communicating to the general public about what the committees are doing – not as a report-out, but as opportunities for representatives of organizations and stakeholder groups to join us as we hold our quarterly meetings throughout the state.

Adam Nelson: Would there be an archival library accessible to the public on the website?

Mr. Keefer: Within the website, there would be past publications that may not directly link to current committee meeting agendas, but you could track back from a committee to past accomplishments.

Dr. Nelson: The Planning Council is concerned with keeping the public informed, and a searchable and accessible website library would be an excellent way to do this.

11. Are Ad Hoc Committees temporary? When will they meet?

Recommendation: Yes, they are temporary in that they are brought together to do something that's very specific. Ideally, they will meet at the time of the quarterly meetings; there may be calls in between meetings that are open to the public.

Dr. Nelson: It might be worthwhile to consider assigning a timeframe when the committees form. Committees should try to confine their work to the allotted timeframe.

Doreen Cease: Regarding the Home Health system coming in: can homeless children and just-released incarcerated youth access that kind of service?

Mr. Keefer: The Children and Youth Committee would be the one to develop that Ad Hoc Committee.

Ms. Shaw: Will Ad Hoc Committees be staffed?

Mr. Keefer: Yes. The caucuses will not.

12. What will be the procedure for the caucus?

We are still looking for a mechanism for a caucus to be formed.

13. Will Leadership Forum continue?

Recommendation: Yes. It has been renamed "Mentorship Forum" to avoid confusion with Leadership.

14. Where is the work of the Human Resources Committee going?

Recommendation: See #9. The work is still here at the Planning Council. The full Council will have a role in fulfilling statutory mandates with OSHPD.

15. Is the role of the Executive Committee being examined?

The new Operations Workgroup and Communications Workgroup will discuss current policy for Executive Committee membership and propose changes, if needed, for the October 2012 meeting.

16. Will subcommittees be staffed separately?

Executive Director Adcock: Right now we have three committees that will grow to four. We are trying to call the others workgroups, so that we can be clear on what's what.

17. Should Realignment be a part of Healthcare Reform?

Mr. Keefer: That isn't a structural recommendation that is required.

18. Should the new Patient's Right Committee be an ad hoc committee or an addition to the 3 standing committees?

Mr. Keefer: This issue will be dealt with later on today's agenda.

Discussion

Ms. Black: The labeling is somewhat confusing, so maybe a flowchart would be helpful.

Mr. Keefer: The committees are already described in the *Operating Policies and Procedures m*anual. There is a discussion in the manual about what each particular committee looks like and what an Ad Hoc Committee does. The workgroups associated with the Executive Committee are included.

5. Continue Discussion of Restructure Issues

Mr. Keefer led the discussion on the April and June meeting format. He began by requesting those who had attended yesterday's Executive Committee meeting to report.

Ms. S. Wilson: Holding it ahead of time was good, as was the prep work.

Dr. Bennett: Attending meetings in the morning is preferable to the evening; the energy level is higher.

Chair Black: This is true. Also, having the Executive Committee meet first allows any issues that come up to be presented to the whole Council on the Thursday or Friday meeting.

Ms. Black: If new items come up in the Executive Committee meeting that haven't been agendized, what does that do in regard to the Bagley-Keene open meeting laws?

Executive Director Adcock: The Executive Committee meetings are open to the public. In the Planning Council meetings, new items would come under New Business.

Chair Black: For transparency, the Executive Committee should provide more information during New Business about what happens during meetings.

Mr. Keefer: The January meeting format will look very similar to the October meeting format. The Planning Council now needs to take a vote on having the April and June meeting format similar to this meeting format.

> ***Motion****: To approve the October/January meeting format for April/June meetings, was moved by Patricia Marrone-Bennett, seconded by Susan Wilson. Motion passed unanimously.*

Chair Black commended the staff on their hard work.

Discussion: Workgroups

Mr. Keefer and Executive Director Adcock introduced a discussion about the workgroups. They explained them below.

- The Planning Council was sure about forming a Communications workgroup for consistent messaging, the logo, a template for PowerPoint, and any other products the Planning Council wants to develop.
- Three to five people, and one from the Executive Committee, will serve on each workgroup.
- The workgroups are staffed.
- The Operations Workgroup will edit the existing *Policies and Procedures* manual, and craft some new proposed policies in light of changes.
- They will meet in between Planning Council meetings.
- The Communications workgroup may look at rebranding for the Planning Council.

Ms. Thal: You could put out the call for volunteers in an email to the entire Council, so that those not present at the meeting would have the same opportunity.

Mr. Shwe: We will probably get some new members in January who may want to volunteer.

Volunteers for the Communications workgroup were Adam Nelson, and Walter Shwe.

Mr. Keefer stated that the Operations Workgroup will look at issues that directly impact how the Planning Council will be functioning procedurally, perhaps even commenting or guiding the charters or guidelines of how committees function.

Volunteers for the Operations Workgroup were Cindy Claflin, Susan Wilson, Monica Wilson, and Karen Hart.

6. 5-Member Patient's Rights Committee Discussion

Executive Director Adcock explained that there were changes included in the trailer bill language this summer that provided the Planning Council with a new responsibility: to form a five-member Patient Rights Committee, with an additional two ad hoc members who have experience in advocacy.

This committee will advise the Director of Healthcare Services and the Director of State Hospitals regarding their department policies and practices that affect patient rights. They are also to review advocacy and patient rights components of each county mental health plan or performance contracts, and advise those directors.

This Committee will be staffed and will operate as the other three committees do.

The trailer bill does not mention locked facilities.

There were two possibilities for the new committee's meeting time:

- The same time as the other committees, and have people leave them to join the new one.
- The same time as the Executive Committee.

Jaye Vanderhurst and Chair Black: The former option contains the problem that people are already assigned to the three committees, and should not have to leave them to join the new committee.

Dr. Nelson: The new committee could meet in the evening when the Executive Committee used to meet.

Mr. Ryan: This committee's task is horrendous. To assess how patient rights are being handled, it seems that they would have to visit the state hospitals, not just to see what's on paper. There would be a fair amount of travel time and commitment. A person could serve only on this committee and not others.

Mr. Ryan: Regarding the two ad hoc members, what about paying for travel for outside experts? Executive Director Adcock replied that there may be an argument for an exception because the two ad hoc members are statutorily mandated.

Ms. Vanderhurst: This is our opportunity to partner with the two state departments that deal with policy to review their departmental policies and policies. The Patient Rights Committee wouldn't be doing oversight in terms of site reviews unless it were asked.

Executive Director Adcock: The committee would need to delve into and interpret the two stated functions (which are rather limited), and determine the scope.

Daphne Shaw: The committee would need to know what is actually happening with policies by seeing them in action at ground level.

Dr. Bennett: How many Planning Council members are actually interested in serving on the committee?

Those who indicated interest by a show of hands were Walter Shwe, Cindy Claflin, Glenn Hutsell, Daphne Shaw, Doreen Cease, Adam Nelson, Pat Marrone-Bennett, and Jaye Vanderhurst.

Mr. Riel: That show of hands indicated a "brain drain" from the other committees.

Ms. Hart: In the past, the Planning Council has visited state hospitals and prisons in association with its meetings in particular geographic area. It has proven not to be too disruptive to schedules and budgets. It can probably be worked out again in this instance.

> ***Motion:*** *The approval of the establishment of the Patient Rights Committee as a fourth committee was moved by Adam Nelson, seconded by John Ryan. Motion withdrawn.*

Mr. Grolnic-McClurg: It may be too much to serve on two committees; if that is the case, people can report back to let us know. We could then change the meeting time to be the same as the other committees.

Mr. Ryan: The committee should be the ones to decide when they will meet.

Dr. Nelson: *Motion to call the question.*

Chair Black: To establish the committee; its members are made up of people serving on other committees; it meets at a separate time.

> **Motion to call the question**: A show of hands resulted in a unanimous vote.
>
> ***Motion:*** *The establishment of the Patient Rights Committee, comprised of individuals serving on other committees, and meeting at a separate time, was moved by Jeff Riel, seconded by Monica Wilson. Motion passed with one abstention.*

Ms. Vanderhurst: For the other committees and the workgroups, how were the charges developed?

Executive Director Adcock: They generated out of the conversation for the restructure. Staff put some proposed language on paper, and they were discussed, edited, and finalized during the meetings yesterday.

Mr. Grolnic-McClurg: For those members not present, there should be a period during which they can volunteer; the Executive Committee would then take the applications and make a decision on the composition of the committee.

Ms. Vanderhurst: We need to understand what the committee is doing before we ask people to sign up.

Mr. Grolnic-McClurg: It may become clear over time to the committee members.

Ms. Hart: The Executive Committee should consider representation of clients, family members, etc.

Pat Marrone-Bennett, Jaye Vanderhurt, and Glenn Hutsell withdrew their interest.

Executive Director Adcock summarized that the Planning Council wished to open the Patient Rights Committee to volunteers; staff would do a brief write-up of the committee;

and the Executive Committee would select from the applications should there be more than five. Regarding the selection of the ad hoc members, she stated that nothing has been decided. The committee members would make concrete decisions.

Ms. Shaw: The WMI code states that the ad hoc members be appointed by the Chairperson.

At this point, Chair Black introduced new Planning Council member Amy Eargle from Corrections, replacing Kathleen O'Meara.

Ms. Eargle described her background: she is Chief of Psychology Support Services with the Mental Health Program at the California Department of Corrections and Rehabilitation (CDCR) at the headquarters level (so she is not affiliated with any particular institution). She has been with CDCR for about 13 years. She has experience doing policies and procedures within CDCR, as well as direct clinical services.

Chair Black then introduced new staff member Linda Dickerson, Ph.D.

Dr. Dickerson stated that she was glad to be working with the Planning Council. She has a Ph.D. in Neuroscience from UCLA with interdisciplinary training, focusing on the interaction of behavior, biological health, and physiology.

Chair Black announced that a Nominating Committee had formed to select the next Vice-Chair-Elect. Committee members are:

Carmen Lee, Direct Consumer
Cindy Claflin, Family Member
Gail Nickerson, Consumer-Related Advocate
Dale Mueller, Provider Professional
Cheryl Treadwell, State Employee

(8.) Approval of the Minutes of the June 2012 Meeting

Motion: *The approval of the June 2012 Meeting Minutes was moved by Patricia Marrone-Bennett, seconded by Susan Wilson. Motion passed with five abstentions.*

At this point, Mr. Ryan drew the Planning Council members' attention to an informational chart tracking the revenue of the public mental health system in California since the year 2003-04. The chart tracks the total revenue and the sources of the revenue.

Executive Director Adcock drew the Planning Council members' attention to another informational document, the Summary of the 2011-12 Bills and Status.

7. Public Comment

Chair Black requested the members of the public in the audience to introduce themselves.

There was no public comment.

9. Report from the Mental Health Services Oversight and Accountability Commission

MHSOAC Executive Director Sherri Gauger introduced Dr. Renee Bradley, the new Research Scientist, heading up the MHSOAC's evaluation efforts.

Executive Director Gauger reported on some business items.

- The MHSOAC elected Richard Van Horn as the new Chair and Dr. David Pating as the new Vice-Chair. Their terms begin January 1. Staff is working with them to develop the 2013 Work Plan.
- The MHSOAC is actively recruiting subcommittee members; some Planning Council members have applied.
- MHSOAC staff is currently in the process of writing the scope of work for the new client contract (National Alliance on Mental Illness [NAMI], the National Alliance on Children and Families [UACF] and CAYEN [California Youth Empowerment Network]).
- In the communications arena, Senate President Pro Tem Steinberg is encouraging the MHSOAC to get the word out on Prop 63. In addition to displaying the new logo, the MHSOAC co-hosts a radio show every Saturday and Sunday. Also, the community forums are continuing on a quarterly basis; the most recent took place in Los Angeles with six different languages and ethnic populations represented.

Dr. Bradley gave a high-level overview of some of the evaluation deliverables to be published soon. She had met the previous day with the Continuous System Improvement Committee and shared details of many of the MHSOAC's evaluation projects.

- As part of a large contract with UCLA, one of the deliverables focuses on costs as well as cost offsets for providing full-service partnerships to individuals throughout the state. They are identifying at both the county level and the state level.
- As part of the same contract, the MHSOAC has asked UCLA to look at a series of performance indicators that the MHSOAC has identified as its priority indicators. They were actually approved by the Planning Council. The MHSOAC has generated a statewide report and an individual-level county report.
- Within the stakeholder review process is a user participatory research process to evaluate a series of services and their impact on a series of client-level outcomes. They used stakeholders – clients, family members, and other types of content experts – to identify specific services that they thought were of high importance to focus on. They chose employment services, peer support services, and crisis intervention services; they looked at the impact on individual outcomes, including housing, education, and general well-being.
- The MHSOAC has just begun two new projects with UC Davis:
    - Access to services or reduction of disparities as a result of the Mental Health Services Act (MHSA).

- Focus on prevention and early intervention programs that are funded via the MHSA.

Ms. Nickerson asked about the small rural counties receiving information. Dr. Bradley said that for priority indicators, if a specific county wanted information, they could request it from UCLA and they would be happy to provide it.

Ms. Hart asked about the scope of work for the new client contract: would there be an opportunity for stakeholder input, or are people presently involved with staff as they write the contract? Executive Director Gauger replied that the MHSOAC has been on a fast track to get the money encumbered for the contract. The only public notice and involvement was at the Commission meeting.

Ms. Hart asked if Executive Director Gauger foresaw the scope of work being similar for next year when the contracts for NAMI and United Advocates for Children and Families (UACF) come up again. Executive Director Gauger responded that she did see them tying together; conversations had already started about how to strengthen the deliverables in the contracts.

Mr. Ryan asked about the UCLA study on prevention and early intervention. Dr. Bradley explained that there are two primary deliverables: costs and clients served; and identification of clusters of programs: trauma-focused Cognitive Behavioral Therapy (CBT), older adults with symptoms of depression, and first-break psychosis.

Dr. Dickerson offered to forward the MHSOAC documents to the Planning Council as they become available.

10. Department of Managed Health Care Help Center

Susan Burger of the Department of Managed Health Care (DMHC) Help Center gave a presentation to share information about who they are, what they do, and how they can help consumers. Below is a summary.

- The Help Center answers any and all health care questions from the public.
- It can process and resolve complaints and disputes that managed care enrollees have with their health plans.
- The staff are experts in consumer rights.
- The DMHC regulates managed health care plans in California: HMOs and PPO products in Anthem Blue Cross and Blue Shield.
- The DMHC protects about 90% of the commercial insurance pool – about 20 million Californians.
- The Help Center tracks every call for trends and issues.
- The DMHC is always looking at the adequacy of provider networks.
- Consumers can call the toll-free number or use the website.
- Consumer rights experts – analysts, clinical staff, and attorneys – work in the teams.

- The following health care rights, named on the website, are honored:
  - To get an appointment quickly.
  - To choose your own doctor within the network.
  - Language assistance.
  - Continuity of care.
  - Parity in deductibles and co-pays.
  - To file a grievance with your health plan. The standard review is 30 days.
- Hours are 7 a.m.-7 p.m. M-F with registered nurses on call on weekends.
- 150 language are served.
- Routine issues between the plan and the enrollee are handled in "Quick Resolution."
- Urgent complaints involve members with urgent Medi-Cal conditions that need immediate resolution; the issues cannot wait 30 days.
- Standard complaints account for the bulk of the calls – about 5400 cases in the last fiscal year.
- The Independent Medi-Cal Review (IMR) process providers consumers and health plans with a means to resolve disputes over Medi-Cal care. An outside Medi-Cal specialist does the evaluation.
- Not everyone is eligible for an IMR, including Medicare beneficiaries and Medi-Cal fee-for-service recipients.
- IMR applications can be obtained by calling the Help Center or downloading from the website.
- When an IMR decision is rendered, it is sent in writing to the enrollee, the enrollee's physician, and the enrollee's health plan. The health plan is required to comply fully with the decision.
- Important statistical numbers are that in 2011, 39% of IMR cases were upheld by the review organization, but 61% of cases were overturned and the consumer got the desired treatment.
- In 2011, 16% of IMRs concerned mental health.

Questions and Discussion

Ms. Thal: Are all PPOs in California included? Is the entire grievance process for PPOs or only HMOs?

Ms. Burger: The DMHC regulates HMOs and the PPO products of Anthem Blue Cross and Blue Shield; the rest are with the California Department of Insurance. The grievance process is for the people under those plans (90% of the commercial business in California).

Ms. Burger: Out-of-network issues – getting providers that were not contracted with their health plans – were big for mental health IMRs.

Mr. Ryan: For managed care enrollees' health rights to receive care when you need it ("access standards"), is the time period one week?

Ms. Burger: It varies; it is tied to the type of provider.

Mr. Ryan: If someone goes for an intake interview within the 10 days, and the provider then says they need treatment, but the first available appointment is many weeks out although the consumer feels the need to see someone way before that – is that a complaint?

Ms. Burger: Yes. The timely access regulations talk about specialists; that is a 15-day wait limit.

Dr. Nelson: How does the DMHC deal with insurance companies or other managed care carriers that remain out of compliance even when a decision is overturned?

Ms. Burger: They are fined.

Dr. Nelson: In mental health care, many barriers prevent clients from accessing services. They may use proxies, such as their provider of services, to contact the DMHC. However, the proxy is not entitled to the same responses as the beneficiary who actually initiates a call. Is DMHC going to do anything to help?

Ms. Burger: It certainly is very difficult for individuals with mental conditions to advocate for themselves. On the website are IMR applications and complaint forms. On the last page of each is a line for "Authorized Representative" that you can use.

Dr. Nelson: A statistic from the website: of the number of IMRs that were applied for with mental health claims, 56% were upheld and 44% were overturned, a different number than the rest of the Medi-Cal field. The burden of proof seems to be upon the consumer to disprove the claim of the insurance company that the service was not medically necessary.

Ms. Black: Regarding ancillary services, in my independent living center we serve many deaf people. There are many complaints about consumer appointments being altered so that an interpreter can be supplied. When you receive a call on the videophone and you're speaking through an interpreter, are you going to take the information as though it is through the TDD?

Ms. Burger: I think we are able to receive those calls. I will check and get back to you. All of the timely access and language assistance regulations would apply.

11. Office of Patient Advocate

Barbara Marquez, Deputy Director of the Office of the Patient Advocate (OPA) gave a presentation, summarized below. She was assisted by Barbara Mendenhall, Research Program Specialist and lead on the report card.

- The OPA was closely associated with the DMHC for 12 years.

- Ms. Marquez saw potential collaboration between the work of the OPA and the CMHDA.
- This year the OPA was brought over to the Health and Human Services Agency.
- The OPA mandates are patient rights, partnerships, and public reporting.
- Like the DMHC, the OPA exists to help consumers who are having problems getting the care they need.
- The California Department of Insurance (CDI) is committed to ensuring that consumers who call about health problems get health assistance. They have a special unit just on health.
- The OPA wants to ensure that people make informed health decisions – health navigation is not easy. The OPA also wants to ensure that people receive high quality health care.
- Healthcare reform is a big issue, and OPA is supplying consumer pieces on issues such as interpreter services.
- The OPA banner can be added to websites.
- The OPA does referrals to the DMHC and CDI, and works with the Medi-Cal Ombudsman program.
- The OPA makes its data usable and accessible to consumers. There is also a tremendous amount of interest on the provider end about data and report cards.
- By mandate, the OPA produces an online report card every year. Using clinical scores and patient satisfaction scores, the OPA reports on the nine largest HMOs and the six largest PPOs, as well as over 200 Medi-Cal groups.
- Ms. Marquez and Ms. Mendenhall displayed the OPA webpage showing the rating for the nine largest HMOs in California. They showed ratings for Clinical Care, Consumer Rating, Getting Care Easily, and Plan Service; then they focused on Mental Health Care.
- Ms. Marquez explained what was measured to create composite scores.
- Future enhancements to reporting were the redesigned website, reporting on timely access for the various health plans, and complaint data – AB 922 broadened the OPA audience and gave it a mandate that it is responsible for collecting data from the DMHC, CDI, Department of Healthcare Services (DHCS), Managed Risk Medi-Cal Insurance Board (MRMIB), and the California Health Benefit Exchange (HBEx). The burden is on those agencies to give OPA their complaint data.

Questions and Discussion

Chair Black: Your definition of *consumer* is "those who have insurance."

Ms. Marquez: That was prior to AB 922. Now it is everyone – insured and uninsured.

Mr. Ryan: Regarding the access issue: the length of time between appointments is getting longer and longer after the intake. Having good access doesn't mean having good mental health care. For every standard that is set, you need to look at the creative opportunities the plans have to manipulate it.

Mr. Grolnic-McClurg: How can we guide people who need to know which plans give good service for serious mental illness?

Ms. Marquez: OPA is very interested in working collaboratively with all those who give report cards, especially Medicare and Medi-Cal. Also, consumer testing shows which data is the right data to report.

Dr. Bennett: In the book, in one section you rated whether people are seen within 30 days after hospitalization. For people with serious and chronic mental illness, 30 days is far too long.

Ms. Marquez: Those are national measurements from the National Committee for Quality Assurance (NCQA). There is a whole process on how to change those measurements or get new ones on board. OPA has a relationship with NCQA and can influence the national standards (but not control them).

Ms. Black: Can you talk about the advocacy part of your services?

Ms. Marquez: OPA has an 800 number but a small staff; we refer people to the DMHC Help Center. With our new expanded role with AB 922 we'll have a different perspective. We do take consumer calls and try to help people get to the right place.

Ms. Nickerson: The data doesn't pertain much to rural areas; we don't have HMOs in 28 out of the 58 counties.

Ms. Marquez: Health plans get their data from the Medi-Cal providers who do the work. If OPA could work more closely with Medi-Cal, it could bring in that data as well. We are committed to having the rural areas become a bigger part of the picture.

Ms. Thal: The Planning Council committees should decide if they want to have a collaboration with OPA. They are advocates; we are advocates.

12. Report from the California Mental Health Directors Association

Patricia Ryan, Executive Director of the California Mental Health Directors Association (CMHDA), reported on its activities.

- The CMHDA is spending most of its time discerning how the new Realignment 2011 works. Some of the details of implementation and funding are unclear.
- There are no General Fund dollars left for community mental health; it is entirely outside of the budget. We no longer have to advocate for that.
- There are three dedicated revenue sources outside the state General Fund budget:
    - Realignment 2011
    - 1991 Realignment
    - MHSA

They come in continuous appropriations on a monthly basis.

- Right now, the biggest revenue source overall is Federal Financial Participation (FFP).
- If Proposition 30 doesn't pass, counties do not have constitutional protections against changes in the future to Medicaid, state law, and so on. In addition, it will be much more difficult for the state to continue to fund the realign programs when they have a huge gap in the rest of their General Fund budget.
- There is a major shift in the planning stages for transitioning the Healthy Families program and beneficiaries to the Medi-Cal program. Current Healthy Families kids will become Medi-Cal beneficiaries, eligible for full-scope Medi-Cal – and counties will be responsible for serving those who need specialty mental health services. There hasn't been enough discussion about these services and responsibilities.
- The program that was transferred to counties for drug Medi-Cal is a completely unmanaged program. It has specified benefits, and basically any willing providers in the counties have to pay for those services, but they don't have any way to manage them. CMHDA is talking to the state about how to change that program in the future so that it is managed.
- With the new Department of State Hospitals, we are trying to learn how to deal with the new departments that have taken over some of the mental health responsibilities at the state level.

Mr. Ryan: Regarding the criminal justice realignment: is there caution going on between the state and the counties? People coming out of the state prison system had the state paying for their mental health care while they were in; now the same people are residing in the communities, and the counties have received "x" amount of dollars to provide a range of services for them.

Ms. Ryan: We recently surveyed counties to ask how much of the AB 109 Public Safety funds have been dedicated to substance abuse and mental health. There has been a wide range of answers, depending largely on the politics of each county.

Mr. Ryan: Regarding the newspaper article by Rose King: the CMHDA had drafted a response with a list of talking points. A heads-up would be useful for the CMHPC to ensure that a uniform message is going out to the public regarding mental health.

Ms. Ryan: We are happy to share what we have.

Dr. Bennett: Are you seeing sheriffs and others advocating for treatment services to happen not on the outside, but on the inside, resulting in re-entry facilities being built inside jails?

Ms. Ryan: I have strongly advocated for programs that provide effective models for the local levels. There is indeed an interest on the part of some law enforcement people to keep the money so they can spend it on jails and so on. CMHDA advocates for people to get involved at the local level and speak up when these issues come before the Boards of Supervisors.

Ms. Vanderhurst: When Planning Council staff and members receive information from the CMHDA, we should make sure to share it.

Executive Director Adcock: As Planning Council staff keeps tabs on issues coming up, perhaps we can dialogue back and forth with the CMHDA.

Ms. Ryan: Absolutely.

Mr. Ryan: There's an opportunity for a partnership – when the CMHDA sees issues that the Planning Council should have on our radar, please inform us so we can advocate. We are also connected to the local Mental Health Boards, who are always looking for issues; we need to help them become advocates at the local level.

Ms. Ryan: It would be very good for Mr. Ryan and Executive Director Adcock to come to a Governing Board meeting to have that dialogue and try to identify issues for partnership.

Ms. Shaw: There is information that should get disseminated among all the mental health organizations.

Ms. Ryan: I agree. We are so involved in Proposition 30 and the implementation of Realignment that we forget that other people don't know as much as they should. CMHDA is putting out a list of talking points of Proposition 30 in relation to the mental health community, which we will share with the Planning Council.

13. Public Comment

Rosa Clark of the Department of Rehabilitation, California Committee on Employing People with Disabilities, commented that currently this committee does not have much mental health representation. We are looking for ways to collaborate and get a mental health voice at the table, involved in our projects on employment issues.

Mr. Riel added that the Governor's Committee of CalCom would very much like to have a high level person from some mental health organization join us on this committee.

Ms. Shaw commented that she consistently receives emails from the Employment Development Department (EDD) from having contact years ago.

Chair Black: The Planning Council seems to be in agreement that a partnership with OPA would be a good idea for the future. The issue will be brought to the committee.

8. RECESS

Chair Black recessed the meeting at 4:46 p.m.

Friday, October 19, 2012

1. Welcome and Introductions

Chair Black brought the meeting to order at 8:39 a.m. He welcomed the Planning Council and audience members; everyone introduced themselves.

(5.) Overview: Department of Healthcare Services Mental Health and Substance Use Disorders Division

Vanessa Baird, Deputy Director of DHCS Mental Health and Substance Use Disorders (MHSUD), spoke about DHCS and its recent changes. Below is a summary.

- As of July 1, 2012, several programs transferred to DHCS:
    - Medi-Cal specialty mental health services
    - Various functions of the MHSA
    - The Substance Abuse and Mental Health Services Administration (SAMHSA) block grant
    - Other functions of community health services
    - The Drug Medi-Cal program, which provides treatment services for those with substance use disorders
- In Ms. Baird's area, they have been organized into two divisions, one of which is the Mental Health Services Division. In July 2013 additional programs may transfer to DHCS and to this division.
- Ms. Baird distributed an organization chart and explained the responsibilities of the Chief Deputy Director and Program Deputy Directors.
- Ms. Baird explained her role as a source of support for CMHPC staff and the conduit for everything that Planning Council members and staff are advising. She also advocates for MHSUD clients with Medi-Cal Fee-for-Service and Medi-Cal Managed Care.
- After the significant changes AB 100 made to the MHSA and the responsibilities of the state agencies (particularly the former Department of Mental Health), some areas were clarified and put back in with the trailer bill that was just passed, and go to DHCS, OSHPD, and MHSOAC. The environment has shifted significantly.
- DHCS needs to discern its priorities. It has embarked on a process to develop a business plan to help identify its priorities. It contracted with the California Institute for Mental Health (CIMH) and the Alcohol and Drug Policy Institute (ADPI) to implement a process for developing a business plan.
- These contractors have gathered information from stakeholders on what is important. DHCS will now go through a process of prioritizing. The next phase will be to form workgroups for the priority areas, which will again involve stakeholders. The Planning Council has been invited to participate in this process.
- The DHCS has also invited the Planning Council to participate in the development of a performance and outcome system for children's specialty mental health services. It has the charge of providing a plan for this system to the Legislature by October 1, 2013.

- The state has taken action with regard to essential health benefits and the model to follow for the health exchange (the Medicaid expansion).

Questions

Ms. Hart: Will the Stakeholder Advisory Council meetings for the performance and outcome system for children's specialty mental health services be available via teleconference?

Ms. Baird: Yes.

Mr. Ryan: What do you consider your role with regard to the Planning Council?

Ms. Baird: It's a partnership. It may include advocating for the Planning Council in terms of positions it has taken. Executive Director Adcock is the one to advocate for Planning Council budget concerns. Our goal in the DHCS is that we and the Planning Council support each other.

Mr. Grolnic-McClurg: How can we support you in building bridges with the physical health care system as we move toward integration?

Ms. Baird: Counties have been our primary business partners in the actual delivery of mental health services and alcohol/drug treatment services. With Realignment, financing was changed: the state is no longer putting in General Fund dollars for those programs; they are county realignment dollars. Another key partner in that discussion on change is the counties; thus, for the Planning Council to engage in discussions with the counties would be important.

Ms. M. Wilson: There are vacancies on the organizational chart. When will you fill them, particularly the position of Mental Health Services Division CEA?

Ms. Baird: Filling the vacancies is important to me. We are initiating the exam process so that we can get that position filled ASAP.

Dr. Bennett: Health care reform is going to require a lot of leadership to ensure that the people we advocate for, the systems we have built, and the things that work successfully, continue to be part of the framework and delivery system. Are there discussions going on about this regarding mental health services?

Ms. Baird: Realignment and health care reform are going to be a simultaneous process. (Ms. Baird then explained the groundwork process laid for health care reform.)

Mr. George Frye: What is the process to get vacancies on the Planning Council filled?

Ms. Baird: I am working with Executive Director Adcock the review applications and get the vacancies filled.

2. Executive Committee Report

Executive Director Adcock reported the following information from the Executive Committee meeting.

- She provided an update on the Planning Council's transition to DHCS, i.e., email addresses and coding for airline flights.

- The Executive Committee has filled the slots for the Nomination Committee: Carmen Lee, Cindy Claflin, Gail Nickerson, Dale Mueller, and Cheryl Treadwell. They will begin recruitment for the new Chair-Elect to be voted upon in January.
- The Planning Council is having issues with attendance; the Executive Committee agreed to follow the existing Policies and Procedures. Members will be receiving notifications regarding their attendance.
- The Planning Council Matrix documents recent and current activities. The Executive Committee asks everyone to contribute to that list; it will be displayed prominently on the webpage.
- Executive Director Adcock provided an update on the work of the California Stakeholder Process Coalition.

Mr. Ryan added that at a meeting of the Planning Council Committee Chairs (the *Mentoring Group*), they decided to spend one hour per meeting on Planning Council member issues – accomplishments or concerns.

- Mr. Cary Martin, President of the California Association of Local Mental Health Boards (CALMHB) asked the Planning Council to explore areas in which the two organizations can collaborate and have an impact in the mental health arena.

4. Report from the California Association of Local Mental Health Boards and Commissions

President Martin reported on the following CALMHB activities.

- He invited the Planning Council to the CALMHB meeting later at 1:00 at the same venue.
- President Martin spoke about Students in Prevention, a program where students help students in drug prevention – from young kids through college age. Some years ago, President Martin conducted some focus groups with working street narcs. He posed the question of how to best utilize the few dollars available in this quest. Without hesitation, they told him to start at the earliest age possible.
- President Martin then told about the need for education dealing with the information gathered: Data 101, a very interesting tutorial.
- Seeking to invigorate the quest for collaborative ventures and projects, CALMHB requested the Planning Council to create and share a short list of acceptable projects.
- The CALMHB Executive Committee had charged President Martin to convey their approval of the Planning Council's sense of hope instilled by new Executive Director Adcock.
- Having individual regional trainings and meetings has proved to be the most successful format that CALMHB has utilized. Sadly, the necessary resources to do this have vanished.

- President Martin was pleased to report that the number of counties voluntarily contributing support to CALMHB of $300 had increased to 42.

Questions

Chair Black: Did you recently have elections?

President Martin: Yes, in June.

Some of the new officers were present and introduced themselves: Mike Gonzalez, First Vice President; Beryl Nielson, Treasurer; and George Fry, Central Valley Regional Coordinator.

6. Update on Workforce Education and Training

Lupe Alonzo-Diaz, Executive Director of the Health Professions Education Foundation (HPEF), and Acting Deputy Director for the Health Workforce Development Division at OSHPD, gave a presentation for the Planning Council. Below are highlights.

- HPEF is one of the receiving organizations as a result of the reorganization of DMH programs.
- OSHPD is one of the departments within the California Health and Human Services Agency. OSHPD focuses on the quality and infrastructure of health services.
- The Workforce, Education and Training (WET) programs all reside at OSHPD now.
- HPEF is a 501(c)(3) public foundation housed within OSHPD.
- HPEF workforce programs follow five themes: awareness, training and placement, financial incentive, systems delivery, and data.
- The top three priorities are:
    1. Evaluating existing WET programs.
    2. Developing the next Five-Year-Plan.
    3. Stakeholder engagement.
- In going through the process of transferring the contracts and programs, HPEF is committed to providing up-to-date, accurate public information. HPEF is looking at funding, the purpose of each contract, and most important, outcomes.
- Ms. Alonzo-Diaz addressed cultural competence, stipend programs, and the Mental Health Loan Assumption Program (MHLAP), which provides qualified applicants with up to $10,000 in educational loan repayments in exchange for service in the community public mental health system.
- Another program that HPEF administers is the Song Brown Physician Assistant Residency Program, which has added a mental health to address the shortage of individuals who can administer psychotropic medications.
- Ms. Alonzo-Diaz emphasized HPEF's commitment to work with the Planning Council and other government partners with respect to the three priorities.

Questions

Ms. Nickerson: A bill having to do with marriage and family therapy did not pass; it seems like a big waste of resource that people who are licensed to provide therapy services cannot for Medi-Cal services, because the name of their licenses is different.

7. Affordable Health Care and California

Jon Perez, Ph.D., Regional Administrator, Region IX, SAMHSA, U.S. Department of Health and Human Services, gave a presentation about what SAMHSA is doing at a national level and how that translates down to the regions; expenditures and block grants; and how this all fits with health reform.

- Mental health, substance abuse, and behavioral health have advanced; treatments have improved over the course of the last 30 years because of our understanding and ability to intervene, and to have effective programs.
- SAMHSA is a $3.4 billion federal agency. As of FY 2013 SAMSHA is on a "continuing resolution" – not a real budget, but a number coming from the federal Legislature to keep the government running.
- People know of SAMHSA through block grants and discretionary grants.
- Dr. Perez reviewed SAMHSA's core functions.
- SAMHSA has connections with many entities, both government and private, throughout the region. It has many different offices and four centers.
- Dr. Perez's interest is in building programs. His presence in Region IX is starting to shift how SAMHSA does business with the state and the region. Communicating effectively during a period of dynamic change is key.
- Health reform is uncharted territory. The Affordable Care Act consists of 12,000 pages. Its four basic foundations are:
    1. To expand coverage.
    2. To better integrate care.
    3. To put prevention and wellness as central goals.
    4. To see outcomes.
- Health reform is being driven by multiple forces, not all of which are health – there are also political and economic forces.
- Part of Dr. Perez's guidance to states is to try different things to see what works.
- In California, about two million more people will be eligible for service. We will see a significant jump in people with behavioral health issues who are seeking care.
- In Dr. Perez's professional opinion, we haven't had systems of care with ways to connect people up. We have had systems of providers providing care within various agencies.

- "Health Homes" are insurance organizations that specialize in Medicare/Medicaid reimbursement, and accountable care organizations.
- Heath reform codified parity in much stronger language than the 2008 Mental Health Parity Act. It says that essential health benefits have to include mental health and substance abuse.
- As these programs are being developed, the way the treatment plan and the treatment team adjust to the specific needs of the patient are crucial.
- Dr. Perez stressed the extent to which the Planning Council must connect with and get support from professional colleagues, to be able to provide programs for patients. The amount to which the Planning Council is able to engage will indicate its success.

Questions

Mr. Ryan: All the states are supposed to have Planning Councils; which are doing a great job? Which are good at monitoring and evaluating mental health services in their states?

Dr. Perez: Maine, West Virginia, and Oregon are some; I will get that information to you.

8. Committee Reports

The Committee Chairs reported on their meetings.

Advocacy Committee

Chair Nickerson reported that the Advocacy Committee is reworking the purpose and objectives of its charter.

They also made some revisions to the Planning Council's legislative platform, which Chair Nickerson distributed. The Committee is recommending some discussion.

They discussed how people in recovery from mental health issues may have a past crime on their records, and can't get a new job. The Committee discussed doing a side-by-side comparison with the alcohol and drug people who have a certain licensing protocol. The DSS has one also. The Committee is hoping that they will look for a less restrictive protocol, because finding employment for people in recovery will prevent recidivism.

The Committee passed motions to promote timely advocacy. They must be approved by the whole Council.

Mr. Riel suggested additional language for the Advocacy Committee's legislative platform in the Discretionary Planning section: "…blending *and sustaining* funds."

> ***Motion:*** *The approval of the Advocacy Committee's legislative platform of October 2012 with the abovementioned language addition was moved by Patricia Marrone-Bennett, seconded by Josephine Black. Motion passed unanimously.*

A member of the public commented that NAMI in San Diego uses a style guide for media reporting. He supplied a few copies.

Health Care Reform Committee

Co-Chair Grolnic-McClurg reported that the Health Care Reform Committee agreed on the charter as stated.

They will be working on a subcommittee to set the Work Plan with these elements: Medicaid expansion including the low income health plan, the Exchanges, the dual eligible demonstration projects, Health Homes, and public safety realignment.

Themes that emerged during the meeting were the clear connection between the topic the committee is looking at, workforce issues, and capacity-building.

Continuous System Improvement Committee

Chair Bennett reported that the Continuous System Improvement Committee will be wordsmithing its charter.

They reviewed the mandate of the Planning Council, and how it relates to approving performance indicators and reporting on the system. They looked at what they might build into a Work Plan that would result in the committee helping to fulfill those mandates.

They have formed a subcommittee to examine the work the committee hopes to do in partnership with CALMHB and local Advisory Boards with what was referred to as the "Workbook."

Reviewing the performance indicators that were approved by the Planning Council in 2010 will be part of the committee's work.

They discussed producing a scorecard that would indicate hospitalization rates in counties.

9. Public Comment

George Fry, representing himself, expressed appreciation for the work of the Planning Council officers and Executive Director, as well as the mentoring group that had met the previous night.

Carol Morozevich of the Berkeley Mental Health Commission, speaking in an individual capacity, expressed concern about AB 109. Although Probation is supposed to be coordinating with community partners, there isn't the money for them to be involved. Ms. Morozevich was not satisfied that those with mental illness who are being released from the state correctional system are getting the necessary services. Also, a significant number of people being released from prison are now homeless but are not being tracked.

10. New Business

Mr. Ryan stated that he felt that the Planning Council should consider going to Senator Steinberg and recommending that the Planning Council and the MHSOAC be integrated. There is an overlap in the roles and responsibilities of the two, but the MHSOAC has a much larger budget. Mr. Ryan suggested putting this item on the agenda for January.

Dr. Bennett asked if it would be useful to have additional Planning Council members present at their next meeting with the MHSOAC. Chair Black assured her that this would indeed be helpful.

Mr. Shwe felt that the entire Council should be able to vote on a final decision; Mr. Ryan assured him that it would.

Ms. M. Wilson proposed that some kind of communication be sent out via email to all Planning Council members on this important issue. All need to be thoroughly informed. In addition, she asked if the informal meetings could be announced to the whole Planning Council. Mr. Ryan replied that no meetings have yet been scheduled. He did believe that the discussion should be open.

Ms. Vanderhurst commented that members of the Planning Council would like to see what a model would look like. Mr. Ryan responded that the agenda for the informal discussion was to look at each organization's charge.

> ***Motion:*** *The formation of a subcommittee to examine this issue, explore all options, and communicate with the MHSOAC between now and January was moved by Steven Grolnic-McClurg, seconded by Susan Wilson. Motion passed with one abstention.*
>
> ***Motion:*** *For the Executive Committee to find interested parties and then appoint the members of the subcommittee was moved by Steven Grolnic-McClurg, seconded by Susan Wilson. Motion passed with one abstention.*

Ms. Hart cautioned that there were two separate issues present; the Planning Council would be meeting with the MHSOAC to talk about the division of labor. Also, for the two organizations to merge, some formidable obstacles would have to be overcome. The Planning Council mission would have to remain intact.

11. ADJOURN

Chair Black adjourned the meeting at 12:01 p.m.